AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

EXPIRATION DATE: This authorization will expire in 60 days unless indicated below. **Today's Date:**_____

- ❑ Please change the expiration period to last for _____days.

Patient information:

Patient's Name:_____ Date of Birth:_____
Street Address:_____ Social Security Number:_____
City, State, Zip:_____ Maiden/other names:_____
Home phone: _____ Work phone:_____

Person/ Organization providing the information:

Name:_____ Phone Number:_____
Address:_____ Fax Number: _____
_____

Type of Release:___Paper copies of records___Permission for staff to discuss care ___Onsite review of records

Person/ Organization receiving the information:

Name:_____ Phone Number:_____
Address:_____ Fax Number: _____
_____

Reason for Release:___Continued patient care___Personal use ___Legal use___Insurance/ benefit use

Dates of Records: I would like records from the following dates: _____through _____

Records to be released: Please check all records which you authorize to be released to the receiving party:

Hospital:

- ❑ Discharge summary
- ❑ X-ray report(s)
- ❑ X-ray film(s)
- ❑ ER notes
- ❑ Operative report(s)
- ❑ Pathology report(s)
- ❑ Laboratory report(s)
- ❑ Other (please specify):

Clinic (specify which clinic):_____

- ❑ Office Visit Notes
- ❑ Laboratory Report(s)
- ❑ GYN Notes/ Report(s)
- ❑ TB Screening
- ❑ Billing records
- ❑ X-ray Report(s)
- ❑ X-ray Film(s)
- ❑ Pathology report(s)
- ❑ Psychological test report(s)
- ❑ Immunization record(s)
- ❑ Other (please specify):

I understand that the medical information in these medical records is privileged, confidential protected health information, and therefore subject to disclosure only upon my authorization, except where provided by law. This authorization and consent shall specifically include but is not limited to the release of medical information and/ or medical records relating to any psychological or psychiatric, alcohol and/or drug abuse treatment, HIV testing and/or treatment. I also understand that only the information that is deemed to be reasonably necessary shall be released and disclosed in order to satisfy the persons or organizations requesting or needing the information or records. **However, I understand that there is the potential for information disclosed pursuant to this authorization to be redisclosed and therefore no longer covered by this authorization.**

I understand that treatment, payment, enrollment in any health plan, or eligibility for benefits is <u>NOT</u> conditioned upon signing this authorization.

I understand that I have the right to:

- **inspect or copy the protected health information to be used/ disclosed as permitted under federal or state law;**
- **revoke this authorization at any time by submitting a signed writing so indicating**, and that I have been informed of the same. I understand that no action can be commenced against anyone as provided in the release below, for disclosures made pursuant to my authorization and prior to my revocation thereof.
- **refuse to sign this authorization.**

By completing this form, I release and hold harmless Crawford Hospital District, Crawford Memorial Hospital, its directors, medical staff, employees, agents, representatives from any and all liability that may arise due to the disclosure of information and/or medical records as authorized herein. Further, should I decide to revoke this authorization, I agree to release and hold harmless the aforementioned parties for any disclosures made prior to the receipt of my written notice of revocation of this authorization.

I HAVE READ AND UNDERSTAND THE INFORMATION INCLUDED IN THIS FORM. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT/ I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE-STATED TERMS.

_____ _____

Date Printed Name of the authorizing patient/ party

STAFF: if the patient is unable to sign, secure the consent of the legal representative and indicate the reason below: Patient is a:

- ❑ Minor
- ❑ Incompetent
- ❑ Deceased
- ❑ Other reason:

Proof of designation must be filed in the chart or sent with the request.

_____

Signature of the authorizing patient/ party

_____

Witness

STAFF USE ONLY:

*** Client/ personal representative refused to sign this authorization:

_____ _____

Signature of CMH personnel Date

Date information released: _____ Information released by: _____